RAND HEALTH

Models of Care for Co-Occurring Disorders

Presentation to COCE/COSIG Workgroup

May 17 2007

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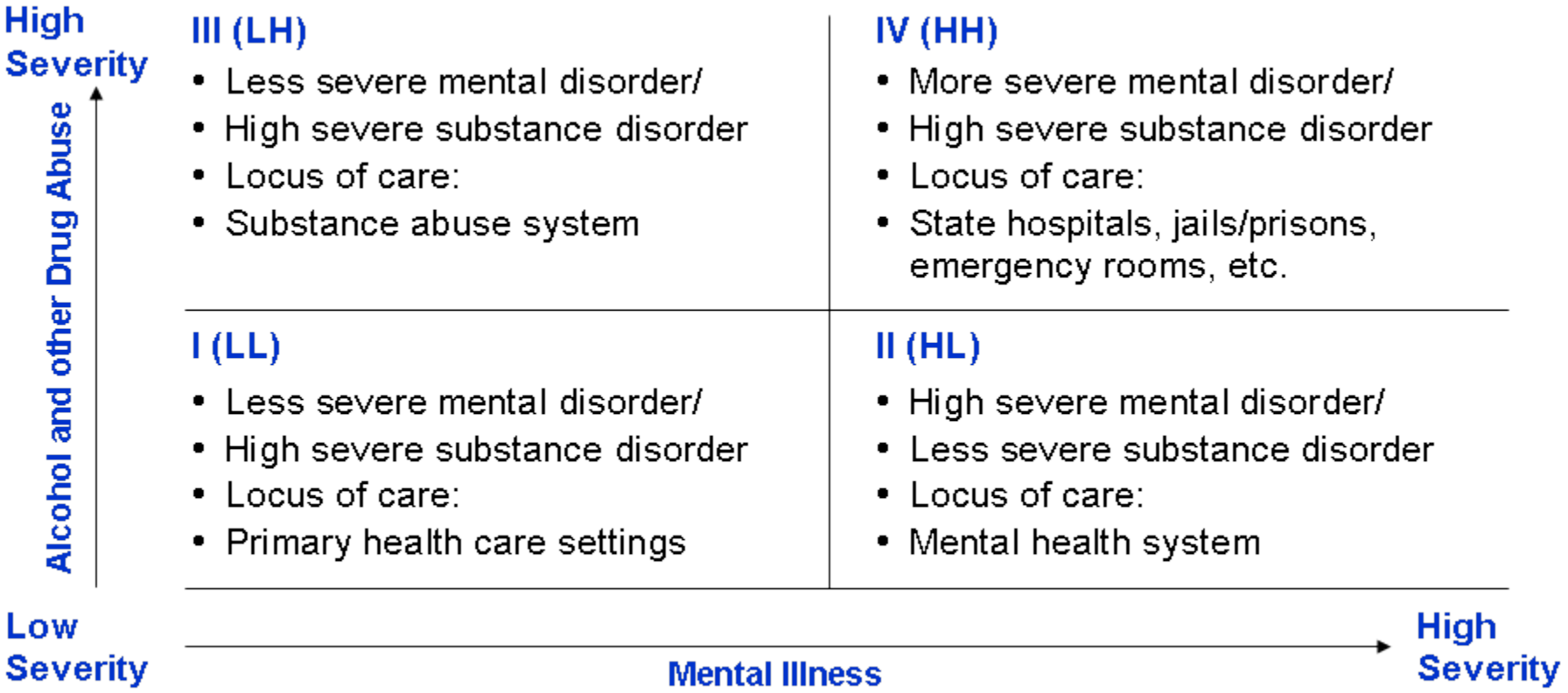
The 4-Quadrant Model Categorizes Individuals in Terms of Symptom Severity, Locus of Care, and Level of Required Service Coordination

Co-occurring matrix and primary locus of care by severity



Source: NASMHPD and NASADAD, 1998

Limitations of 4-Quadrant Model

- **Severity is not explicitly defined**
- **Lack of correspondence between quadrants and specific treatments and settings**

Goal of Study

Further explicate the quadrant model to guide federal and state efforts to improve service delivery for COD

Improved Service Delivery = **Increase in the proportion of people receiving effective health services for their specific treatment needs**

Study Questions

1. **The clinical and diagnostic characteristics of patients in each quadrant**

2. **Associated service systems and settings**

3. **Appropriate clinical interventions for each quadrant**

4. **Barriers, obstacles, and recommendations to delivering recommended interventions**

Methods

1. **Literature Review**

2. **Expert panel input on critical aspects identified from literature review (50 clinical, policy, and research experts)**

Critical Aspects Identified by the Literature Review

- **Defining and operationalizing severity**
- **Types of COD populations encountered by providers in different treatment settings**
- **Identifying recommended care that providers within each treatment system should be able to deliver**
- **Goals (requirements), obstacles, and recommendations for delivering recommended care**

Result: Severity

- **No consensus on how to define the continuum of severity**
- **Quadrant model never intended to create a correspondence between quadrant membership and specific treatments and treatment settings**
- **Planning for service improvement should not be done by quadrant**

Result: Where Are the Different COD Populations Found?

	Schizophrenia	Bipolar	Depressive Disorders[1]	Panic Disorder	Generalized Anxiety Disorder[1]	Other PTSD	Axis II[2]
Hazardous/Problem Alcohol Use[3]	MH	PC, SA, MH	PC, MH	MH, PC	PC	MH, PC	PC, MH, SA
Alcohol Abuse[3]	MH	SA, MH	PC, MH, SA	MH, PC, SA	MH, PC, SA	MH, SA	PC, MH, SA
Alcohol Dependence	MH	SA, MH	PC, MH, SA	MH, PC, SA	MH, PC, SA	MH, SA	MH, SA
Any Stimulant Use (inc. cocaine, amphetamines)	MH	PC, SA, MH	SA, PC, MH	PC	PC	SA, PC	SA, PC, MH
Stimulant Abuse (inc. cocaine, amphetamines)	MH	PC, SA, MH	MH, SA	MH, SA	MH, SA	MH, SA	SA
Stimulant Dependence (inc. cocaine, amphetamines)	MH	SA, MH	MH, SA	MH, SA	MH, SA	MH, SA	SA
Any Opiate Use (inc. prescription drugs)	MH	PC, SA, MH	SA, PC, MH	PC	PC	PC	PC, MH
Opiate Abuse (inc. Prescription drugs)	MH	PC, SA, MH	MH, SA	MH, SA	MH, SA	MH, SA	SA
Opiate Dependence (inc. prescription drugs)	MH, SA	MH, SA	MH, SA	MH, SA	MH, SA	MH, SA	SA
Any Hazardous Drug Use[3]	MH	PC, SA, MH	PC	PC	PC	PC	PC
Polysubstance Dependence	MH, SA	SA, MH	MH, SA	MH, SA	MH, SA	MH, SA	SA

Abbreviations: MH – Mental Health Care System, SA – Substance Abuse Treatment System, PC – Primary Care System
Footnotes: [1] Mertens et. al. 2003, [2] From Table 11 National Mental Health Statistics. Source 1997 Client/Patient Sample Survey CMHS, SAMHSA, [3] Mertens et. al. 2005, [4] From Primary Care: America's Health in a New Era, [5] See Havassy BE, AJP Jan 2004 "Comparisons of Patients with …"

Results: Recommended Care for People With COD

Link specific, recommended services across the continuum of care to treatment systems

Results:

- **Goals (Requirements), Obstacles, and Recommendations**

Conclusions

- **Despite its historic usefulness, the quadrant model is limited in its ability to guide delivery of COD treatment services**
  - **No anchored definitions of severity**
  - **No correspondence between quadrants, treatments, and settings**

- **Planning for service improvement should be done using evidence-based clinical principles of treatment matching, using the client's readiness level**

A range of effective treatment services exist which are likely to improve outcomes, but important policy barriers exist for their effective implementation

Evidence-based intervention	Barriers	Recommended policy changes
Screen for substance use, psychiatric disorders, and risk of harm to self and others	No billing code for mental health/ substance use screening; lack of standardized screening and assessment tools used by both substance abuse treatment and mental health care providers	Enhance the flexibility of Medicaid funding so that comprehensive screening can be paid for; reform the current design and implementation plan for the National Health Information Infrastructure to better address the information-care-support needs of the COD and substance use/mental health population; incentivize mental health/substance abuse care providers to use IT more widely for clinical care support

A range of effective treatment services exist which are likely to improve outcomes, but important policy barriers exist for their effective implementation, continued

Evidence-based intervention	Barriers	Recommended policy changes
If screening is positive, refer to a licensed addiction and mental health professional with experience in COD for further assessment	No consistent provider certification and licensing requirements for COD treatment programs	Develop a uniform basic level of COD competencies across states for mental health and substance abuse treatment providers, and a less comprehensive set of competencies for primary care providers; incorporate COD subject matter, and population-specific professional competencies in training programs, educational preparation programs, licensing standards, and certification requirements; incentivize programs to have their clinical supervisors get a post-masters certificate in clinical supervision and to be fully cross-trained and/or cross-licensed in both areas; establish a national certification for COD clinicians, on the basis of which each state should develop program certification standards for dual-diagnosis enhanced programs (that use fidelity tools), requiring that all programs be dual-diagnosis capable and have basic competencies; states should consider additional/alternative incentivizing mechanisms (e.g., offering higher reimbursement rates), to enhance providers' compliance with the new set of certification standards

A range of effective treatment services exist which are likely to improve outcomes, but important policy barriers exist for their effective implementation, continued

Evidence-based intervention	Barriers	Recommended policy changes
Prior to the referral, ensure that clinical information can be shared between providers and that follow-up on the referral can be done with both the provider and the consumer	No mechanism for the sharing of clinical information in 'real' time, with optimal ways of communicating proof of written consent	Equalize within- and across-state statutory requirements governing the confidentiality of mental health and substance use patient information (e.g., by requiring all providers to follow HIPAA and 42 CFR Federal Guidelines in the sharing/transfer of confidential information)

A range of effective treatment services exist which are likely to improve outcomes, but important policy barriers exist for their effective implementation, continued

Evidence-based intervention	Barriers	Recommended policy changes
Determine appropriate provider(s) of services based on clinical need	No consistent provider certification and licensing requirements for COD treatment programs; system-specific funding streams prevent substance abuse treatment providers from accessing mental health care funding, and vice-versa (e.g., federal block grant funds); many necessary services are not covered under one funding stream or the other; certain populations of COD patients are not covered by one funding stream or the other	Expand the adoption of CSAT's addiction counseling competencies as the basis for States' education and training requirements; incentivize more states to use flexible block grant funds and state dollars to provide "cross-over" funding for COD services; create options enabling providers to "braid" different sources of funding (as in the financing of children's services) to provide integrated services; enable providers servicing patients simultaneously (such as a mental health and a substance abuse specialist) to bill for joint services under a joint treatment plan and that billing for COD services can be done under separate billing streams

A range of effective treatment services exist which are likely to improve outcomes, but important policy barriers exist for their effective implementation, continued

Evidence-based intervention	Barriers	Recommended policy changes
Collect and integrate performance, quality improvement and outcomes information about both mental health and substance use problems	No mechanisms for incentivizing good quality of care/ penalizing poor quality of care	Shift the current focus of IT systems from its current core—the complicated billing, reimbursement, and regulatory reporting requirements for mental health/substance abuse health care—to monitoring the quality of delivered care, communication among care providers, knowledge management, clinical decision-making support and error mitigation

A range of effective treatment services exist which are likely to improve outcomes, but important policy barriers exist for their effective implementation, continued

Evidence-based intervention	Barriers	Recommended policy changes
Use the best medication available that matches the needs of the patient and presumptive diagnoses	Substance abuse treatment providers generally do not have staff that can provide pharmacologic treatment, including medications for addictive disorders (or only have it at a very limited basis, for example, 4 hours/week); many necessary services are not covered under one funding stream or the other	Incentivize more states to use flexible block grant funds and state dollars to provide “cross-over” funding for COD services; create options enabling providers to "braid" different sources of funding (as in the financing of children’s services) to provide integrated services; enable providers servicing patients simultaneously (such as a mental health and a substance abuse specialist) to bill for joint services under a joint treatment plan

Next Steps

- **Circumvent or remove identified policy barriers**
- **Operationalize recommended care at the clinical level and develop treatment protocols for each element of recommended care**
- **Develop performance and quality improvement measures that track and incentivize outcomes of care, not just processes of care**